Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

August 13, 2008

Jack St. Clair, Director
Cherry Hospital
201 Stevens Mill Road
Goldsboro, NC 27530

RE: CMS Certification Number (CCN): 34-4003

Dear Mr. St. Clair:

Institutions accredited as hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are deemed to meet all of the Medicare Conditions of Participation for hospitals, with the exception of utilization review and the special staffing and medical record requirements for psychiatric hospitals. Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct surveys of accredited hospitals participating in the Medicare program if there are "substantial allegations" indicating serious deficiencies that could potentially affect the health and safety of patients.

A survey was conducted at Cherry Hospital on August 9, 2008, with immediate jeopardy being identified. A copy of the deficiencies cited during the August 9, 2008 survey is enclosed. Specifically, the facility does not meet the following conditions of participation:

42 CFR 482.12 Governing Body
42 CFR 482.13 Patients' Rights
42 CFR 482.23 Nursing Services

When a hospital, regardless of its JCAHO accreditation status, is found to be out of compliance with one or more Conditions of Participation, and immediate or serious threat to patient health and safety exists, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of Cherry Hospital and accordingly, the Medicare provider agreement between Cherry Hospital and the Secretary of the Department of Health and Human Services is being terminated. This termination will be effective **September 1, 2008.**

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after September 1, 2008. For patients admitted prior to September 1, 2008, payment may continue to be made for a maximum of 30 days for inpatient hospital services furnished on or after September 1, 2008. You should submit as soon as

possible, a list of names and Medicare claim numbers of beneficiaries in your hospital on September 1, 2008, to your fiscal intermediary to facilitate payment for these individuals.

We will publish a public notice in a local newspaper prior to the termination date. Termination can only be averted by correction of these deficiencies by September 1, 2008. Should we not hear from you, we will assume that the situation has not been corrected. **If you believe that compliance has been achieved, you should notify CMS and the North Carolina State Survey Agency in writing on or before August 23, 2008, describing in detail the specific corrective measures taken to resolve these problems and include acceptable completion dates.** ***An acceptable plan of correction must contain the following elements:***

1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
4) The title of the person responsible for implementing the acceptable plan of correction.

If your "credible allegation" of compliance is accepted, the State Survey Agency will be authorized to conduct a resurvey to determine if the conditions which constituted immediate jeopardy have been removed and a full survey of all conditions of participation. Please be advised, however, that failure to remove conditions that constituted immediate jeopardy will result in your hospital's termination under Medicare, effective September 1, 2008. If the Centers for Medicare & Medicaid Services determines that the reasons for termination remain, the effective date of the termination remains September 1, 2008, and you will be so informed in writing. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

If you believe that this termination decision is incorrect, you may request a hearing before an Administrative Law Judge (ALJ) at the Departmental Appeals Board, Department of Health and Human Services. Procedures governing this process are set out in section 42 CFR 498.40, et seq. To be effective, a written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to the following address:

Sandra M. Pace
Associate Regional Administrator
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

We will forward your request to the Departmental Appeals Board. The request for a hearing should state why CMS's decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and

Human Services. Evidence and arguments may be presented at the hearing, and you may be represented by legal counsel.

If there are any questions, please contact Janetta Booker at (404) 562-7343.

Sincerely,

Janetta Booker for

Sandra M. Pace
Associate Regional Administrator
Division of Survey & Certification

Enclosure
CMS 2567

cc: JCAHO
State Agency

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344003	A. BUILDING _____ B. WING _____	C 08/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS *	A 000		

An unannounced onsite investigation was conducted from 08/08/2008-08/09/2008 in order to determine the hospital's compliance with the Conditions of Participation.

Based on survey findings, an immediate jeopardy was identified and was determined to be ongoing as evidenced by the following:

1. Record review of Patient #1 [redacted] admitted under [redacted] to the 3 West Ward of the U2 Building on [redacted] The review revealed Patient #1 choked after receiving medication administered by unlicensed personnel (HCT) on 04/28/2008 at 2020 and subsequently fell. The medication nurse (LPN) failed to respond to the emergency, failed to assess the patient after the incident and failed to report the incident to the charge registered nurse. The charge nurse (RN) failed to assess the patient, failed to report the incident to the supervisor, delayed reporting the choking incident to the physician's assistant (PA) and failed to report the fall to the PA. Patient #1 sat down in a chair in the dayroom (high traffic area) on 04/28/2008 at 2225 after the fall and choking incident at 2020. The patient remained in the same chair for 22 hours and 34 minutes. The patient was seated in the chair over a duration of four different shifts of care providers: evening shift on 04/28/2008, night shift on 04/28/2008, day shift on 04/29/2008 and evening shift on 04/29/2008. Staff members failed to follow physician's orders for fluids and vital signs. Staff failed to offer fluids, nutrition and toileting assistance during the 22 hours and 34 minutes that the patient remained in the chair in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 dayroom. Facility staff failed to ensure Patient #1 was rendered care for excess of 22 hours, which resulted in patient neglect. 2. Record review for patient #2 revealed an [redacted] admitted under [redacted] to 3 East Ward of the U2 Building on [redacted]. Record review and staff interviews revealed a staff physician on 4/28/2008 between 0830 and 0840 failed to utilize a therapeutic approach to redirect a patient's behavior resulting in the physician being bitten by the patient and the physician subsequently struck the patient on the right shoulder blade to release the bite. Interview with staff revealed the patient was acting out with usual attention-seeking behavior the morning of 4/28/2008 and leading up to the event. Interviews revealed staff were interacting with the patient and had not requested assistance from the physician prior to the physician interaction with the patient, which escalated the patient's behavior. Further staff interview revealed alternative therapeutic approaches which could have been implemented to de-escalate the patient's behavior, preventing staff injury as well as the patient being hit by the physician. The investigation resulted in an immediate jeopardy to patients' health and safety beginning on 08/28/2008 at 0836. The findings were discussed with the administrative staff on 08/09/2008 at 1530. The facility failed to have systems in place to ensure patients received care to prevent abuse and neglect of patients and to ensure care rendered was accurately documented. The IJ was not removed.	A 000		
A 043	482.12 GOVERNING BODY	A 043		

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A 043	Continued From page 2 The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on policy review, closed record review, digital video recording review, investigation reports review, physician credential files review and staff interview, the hospital's governing body failed to provide accountability and oversight to ensure an organized nursing service with systems in place to prevent neglect. The facility staff failed to assess, supervise and monitor the delivery of care to assure basic needs (toileting, nutrition and hydration) were provided and failed to ensure medication was administered by licensed, trained staff. The hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. The hospital's governing body failed to ensure protection of patients' rights as evidenced by failing to prevent neglect, failing to provide a safe and therapeutic environment and failing to notify a patient's guardian of an abuse investigation. The governing body failed to ensure the suspension of physician's priviliges was reported to the state Medical Board as defined by North Carolina General Statute 90-14.13. The findings include: A) The facility failed to ensure Patient #1 was rendered care for excess of 22 hours, which	A 043		

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A 043	Continued From page 3 resulted in patient neglect for 1 of 3 sampled records (#1). ~cross refer to 482.13(c)(3) Patients' Rights Tag A0145 B) Staff failed to provide a safe environment for a patient with mental illness and mental retardation by failing to implement therapeutic measures in order to prevent an escalation in the patient's aggressive behavior for 1 of 3 sampled records (#2). ~cross refer to 482.13(c)(2) Patients' Rights Tag A0144 C) Staff failed to notify a patient's guardian of an investigation for an allegation of physical abuse of a patient by facility staff for 1of 3 sampled records (#2). ~cross refer to 482.13(a)(2)(ii) Patients' Rights Tag A0122 D) The hospital's nursing staff failed to assess, supervise and monitor the delivery of care to assure basic needs (toileting, nutrition and hydration) were provided for 1 of 3 sampled records (#1). ~cross refer to 482.23(b)(3) Nursing Services Tag A0395 E) The hospital's staff failed to ensure the delivery of care was provided to prevent neglect as evidenced by failing to provide supervision, toileting needs, nutritional needs and hydration for 1 of 3 sampled records (#1).	A 043		

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A 043	Continued From page 4 ~cross refer to 482.23(b) Nursing Services Tag A0392 F) The hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. ~cross refer to 482.23(b)(5) Nursing Services Tag A0397 G) The hospital failed to ensure medication was administered by licensed, trained staff for 1 of 3 sampled records (#1). H) Leadership staff failed to report suspension of a physician's privileges to the state Medical Board as defined by North Carolina General Statute 90-14.13 for one of one physician credential files reviewed with an allegation of abuse towards a patient (Physician A). Review of facility policy "Abuse/Neglect/Exploitation of Patients, Prohibited" dated 02/19/2008 revealed "II. Abuse, Neglect, Exploitation Investigation Process (Adults and Juveniles)...B. Responsibilities of the Investigating Supervisor...c....If the accused staff member is a licensed professional the clinical supervisor of the accused staff member will be responsible for meeting all reporting/notification requirements as required by the licensure board of the professional." Review of Administrative Policy, Section II "Investigatory Placement with Pay" dated 11/22/2005 revealed "Purpose: To provide guidelines/restrictions for suspension of an employee with pay when such action is deemed necessary to adequately complete an investigation and assure safety of patients and	A 043		

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A 043	Continued From page 5 staff." Credential file review for Physician A revealed a hand-delivered letter dated April 30, 2008 from the Physician Clinical Director regarding "Investigatory Placement with Pay" addressed to Physician A. Further review revealed "As per our discussion on April 29, 2008, and in accordance with the Administrative Policy Manual, section II, you are being placed on investigatory placement with pay effective immediately. This period of investigation should last no longer than thirty (30) days...During this period of investigation, you may not return to the job site without my prior authorization...You are to turn over your keys, ID badge, and pager which will remain in my possession until the investigation is complete." Review of time sheets for physician A revealed the physicians usual day off was 4/30/2008 and was on administrative leave 5/01/2008 through 5/11/2008, was on vacation 5/12/2008 through 5/14/2008 and was back at work 5/15/2008. Interview with the Physician Clinical Director on 8/08/2008 at 1435 revealed the physician was placed on administrative leave effective 4/30/2008 while an allegation of abuse towards a patient by physician A was being investigated. Interview revealed the administrative leave restricted the physician from practicing at the hospital while the investigation was ongoing and until the Clinical Director authorized the physician to return to work. Interview confirmed the allegation of physical abuse of a patient by the physician was substantiated by the hospital's investigation of the incident. Further interview revealed the physician was given work improvement actions which were completed	A 043		

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A 043	Continued From page 8 5/27/2008. Interview revealed the facility leadership did not view the investigatory leave as a reportable event. Interview confirmed the facility leadership failed to report physician A's suspension to practice at the hospital as required by North Carolina General Statutes governing Medicine and Allied Occupations.	A 043		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on policy review, closed record review, digital video recording review, investigation reports review and staff interview, the hospital failed to protect and promote patients' rights as evidenced by failing to prevent neglect, failing to provide a safe and therapeutic environment and failing to notify a patient's guardian of an abuse investigation. The facility staff failed to ensure Patient #1 was rendered care for excess of 22 hours, which resulted in patient neglect for 1 of 3 sampled records (#1). The facility staff failed to ensure a safe environment for a patient with mental illness and mental retardation by failing to implement therapeutic measures in order to prevent an escalation in the patient's aggressive behavior for 1 of 3 sampled records (#2). The findings include: A) The facility staff failed to ensure Patient #1 was rendered care for excess of 22 hours, which resulted in patient neglect for 1 of 3 sampled	A 115		

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A 122	Continued From page 8 procedures, investigation reports and staff interviews staff failed to notify a patient's guardian of an investigation for an allegation of physical abuse of a patient by facility staff for 1 of 3 sampled records (#2). Findings include: Review of facility policy "Abuse/Neglect/Exploitation of Patients, Prohibited" dated 02/19/2008 revealed "H. Notifications Required by Social Workers - The Social Worker shall inform the guardian/legally responsible person/contact person of the allegation of abuse, neglect and/or exploitation and pending investigation by telephone no later than the next working day...The notification will be documented in the medical record." Review of Patient Advocacy "Abuse, Neglect and/or Exploitation Investigation Report" for case #1984 initiated 4/28/2008 and involving patient #2 being hit on the back by Physician A revealed "Immediate telephone notification should be made to the following:...Social Worker (name of staff member) - Date called - 4/28/2008, Time called - 3:05p.m..." Record review for patient #2 revealed an [redacted] admitted to the facility [redacted] Review revealed documentation that patient #2's mother was the legal guardian for the patient. Review of a progress note by Physician A on 4/28/2008 at 0840 revealed "Attempted to take the undershirt he (patient #2) was snapping at patients and staff. Pt (patient) bent his head down and bit this MD on the (L) (left) arm. Unfortunately, instinctively - with my free hand (R)	A 122		

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A 115	Continued From page 7 records (#1). ~cross refer to 482.13(c)(3) Patients' Rights Tag A0145 B) Staff failed to provide a safe environment for a patient with mental illness and mental retardation by failing to implement therapeutic measures in order to prevent an escalation in the patient's aggressive behavior for 1 of 3 sampled records (#2). ~cross refer to 482.13(c)(2) Patients' Rights Tag A0144 C) Staff failed to notify a patient's guardian of an investigation for an allegation of physical abuse of a patient by facility staff for 1of 3 sampled records (#2). ~cross refer to 482.13(a)(2)(ii) Patients' Rights Tag A0122	A 115		
A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. This STANDARD is not met as evidenced by: Based on review of facility policies and	A 122		

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A 122	Continued From page 9 (right) I popped pt in (R) shoulder blade, pushing him & let him dislodge his teeth..." Review of progress notes on 4/28/2008 at 1405 by physician A revealed "Mother notified of incidenL.." Review revealed no other entry in the record regarding the mother being notified of the allegation of abuse and pending investigation. Interview with Patient Advocate #1 on 6/08/2008 at 1140 revealed the advocate completed the investigation for case #1984. Interview revealed case #1984 involved an allegation of physical abuse of patient #2 by Physician A. Interview revealed the social worker was responsible for notifying the guardian for Patient #2 of the physical abuse allegation and the pending investigation. Interview revealed the advocate notified the responsible social worker (SW #1) on the day of the incident (4/28/2008). Further interview revealed once the investigation was completed the allegation of physical abuse of a patient by Physician A was substantiated and a letter was sent to Patient #2's guardian with the findings. Interview revealed that in a week or two later the guardian called and stated she was unaware there was an allegation of physical abuse to her son (Patient #2). Interview revealed the mother communicated she was only notified that her son had bitten Physician A. Interview with SW #1 on 6/08/2008 at 1445 revealed the social worker was assigned to patient #2 on 4/28/2008. Interview confirmed the SW was notified of the event by the Patient Advocate on 4/28/2008. Interview revealed the one of the nurses reported the mother had been notified of the incident so the SW did not make a phone call to the guardian. Interview revealed the SW later found out the guardian was only notified	A 122		

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A 122	Continued From page 10 that patient #2 had bitten Physician A and she was not notified of the pending investigation of the physical abuse allegation. Further interview revealed "I should have called but I didn't". Interview confirmed the mother was never notified upon initiation of the physical abuse allegation investigation. Interview confirmed facility staff did not follow policy on notification of a patient's guardian for any abuse allegation investigation.	A 122		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, investigation reports and staff interviews staff failed to provide a safe environment for a patient with mental illness and mental retardation by failing to implement therapeutic measures in order to prevent an escalation in the patient's aggressive behavior for 1 of 3 sampled records (#2). Findings include: Review of Clinical policy "North Carolina Interventions (NCI)" dated 10-03-2006 revealed "Purpose: NCI is designed to meet the needs of the patients in the least restrictive therapeutically appropriate available setting. NCI teaches prevent(ion)/alternatives, de-escalation, and management of aggressive behaviors through the use of preventative measures and approved	A 144		

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A 144	Continued From page 11 physical techniques." Further review revealed "(Name of facility) is committed to the care, treatment, and rehabilitation of all patients in a humane, safe, and caring environment...Staff shall continuously survey the environment to identify patients displaying evidence of increasing agitation and potential for dangerous behaviors directed towards self or others and intervene with therapeutic communication or other de-escalation techniques immediately." Further review revealed "Procedures utilized in the implementation of NCI shall be in accordance with the following provisions: 1. Positive and less restrictive alternatives shall be considered and attempted whenever possible prior to the use of more restrictive interventions." Review of the "North Carolina Interventions Prevention/Alternatives Workbook" dated 4/20/2002 revealed "Part A Unit 5 Early Crisis Intervention...Sometimes, in spite of everyone's best efforts, people's behavior can begin to escalate or worsen. Even at this point, your goal is to avoid and escalation and to avoid a confrontation. It is still not too late to try some strategies aimed at helping people cool off and calm down. Always look for ways for everyone to gracefully back down or leave." Further review revealed "Monitoring yourself - You can do a self-check. If you recognize that what you're doing might make the stressful situation worse, walk away from it. This is difficult to learn, and, of course, you must not compromise safety." Further review revealed "Re-direction - If a person starts to do something hurtful or harmful that should not be ignored, interrupt the behavior by asking the person to do something else. You may need to help the person get started on the new activity."	A 144		

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A 144	Continued From page 12 Record review for patient #2 revealed an [redacted] admitted [redacted] to the 3 East Ward of the U2 Building on 4/15/2008 for [redacted] Review of a progress note by Physician A on 4/28/2008 at 0840 revealed "Attempted to take the undershirt he (patient #2) was snapping at patients and staff. Pt (patient) bent his head down and bit this MD on the (L) (left) arm. Unfortunately, instinctively - with my free hand (R) (right) I popped pt in (R) shoulder blade, pushing him & let him dislodge his teeth..." Interview with Patient Advocate #1 on 8/08/2008 at 1140 revealed the advocate completed the investigation for case #1984. Interview revealed case #1984 involved an allegation of physical abuse of patient #2 by Physician A which was substantiated at the conclusion of the investigation. Interview revealed that interviews during the course of the investigation substantiated that the physician admitted to hitting the patient in order to get the patient to release the bite. Interview revealed that interviews during the course of the investigation found that the patient did have a reddened hand mark on the shoulder area after the event. Further interview revealed that interviews during the course of the investigation had witnesses who saw or heard the physician hit the patient on the back during the struggle over the t-shirt. Interview with HCT #1 on 8/08/2008 at 0935 revealed the HCT was interacting with Patient #2 the morning of 4/28/2008. Interview revealed HCT #1 had received training in NCI and de-escalation techniques within the last year.	A 144		

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A 144	Continued From page 13 Interview revealed patient #2 was outside of the nurses' station hitting the window with his shoes and fists and making a popping motion with his t-shirt at staff. Interview revealed "This was (Patient #2)'s usual self...most of us know him well". Interview revealed "This was his attention-seeking behavior...he wanted to get back on observation status". Interview revealed patient #2 was exhibiting these behaviors since the HCT arrived on shift at 0700. Interview revealed the HCT was interacting with patient #2 in an attempt to get the patient to hand over the t-shirt since he was popping it at others. Interview revealed Physician A came out of the nurses' station, asked Patient #2 to give him the t-shirt. Further interview revealed that when patient #2 did not hand over the t-shirt, Physician A grabbed the t-shirt. Further interview revealed Patient #2 and Physician A then both began tugging back and forth at the shirt. Further interview revealed Patient #2 bent down and bit Physician A on the arm. Further interview revealed "I didn't see what happened after that - I was trying to control (Patient #2)'s arm from swinging at (Physician A)." Further interview revealed "Next thing I know (Patient #2) was sitting on the floor". Interview revealed the HCT never asked for assistance from Physician A. Further interview revealed "I didn't take the shirt from (Patient #2) because I didn't have an order to take it." Further interview revealed the patient's behavior had not escalated to a level which would require a physical NCI intervention. Interview with RN#1 on 8/08/2008 at 1225 revealed the Registered Nurse (RN) was the charge nurse on 3 East on 4/28/2008. Interview revealed the nurse briefly interacted with Patient #2 at the beginning of the shift. Interview	A 144		

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A 144	Continued From page 14 revealed the patient was exhibiting his usual attention-seeking behavior that morning. Interview revealed the care team of nursing, social workers and physicians were having a patient conference meeting around 0830 on the morning of 4/28/2008 in the nurses' station. Interview revealed RN #1 noticed Patient #2 popping his t-shirt at staff just outside of the nurses' station. Further interview revealed RN #1 got up to go and redirect Patient #2 and was asked by Physician A to sit down and "he said he would take care of it." Interview revealed Physician A left the meeting and when he came back into the nurses' station, RN #1 heard Physician A state that he had hit the patient. Interview revealed "If I would have known that was going to happen (Physician A hitting Patient #2), I would have never sat back down." Further interview revealed "I was going to go out and redirect (patient #2) to a different area to decrease his secondary gain and gratification he was getting from being disruptive."	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on policy review, closed record review, digital video recording review and staff interview, the facility staff failed to ensure Patient #1 was rendered care for excess of 22 hours, which	A 145		

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A 145	Continued From page 15 resulted in patient neglect for 1 of 3 sampled records (#1). The findings include: Review of the "Abuse/Neglect/Exploitation of Patients, Prohibited" policy effective 02/19/2008 revealed neglect is defined as the failure to provide necessary care or services (medical or otherwise) to maintain the mental health, physical health and/or well-being of the patient. The policy revealed "Examples of abuse or neglect include, but are not limited to, the following: 8. Failure to carry out orders for treatment (excluding medication variance process); 9. Failure to care for the patient's basic needs; 10. Failure to provide a required level of supervision." Closed record review of Patient #1 revealed [redacted] admitted [redacted] with [redacted] Review of the medication administration record (MAR) revealed four oral medications were administered on 04/28/2008 at 2000 by LPN #1(licensed practical nurse). Review of a nursing note by LPN #1 dated 04/28/2008 at 2020 documented "Pt. (patient) was taking his po (oral) meds and started choking. Heimlich maneuver was used and patient was assisted out of interview room. Pt. was able to stand up and walk with assistance to bed. Pt. was breathing without difficulty." Review of the record revealed a note by PA #B (Physician Assistant) dated 04/28/2008 at 2200 (1 hour and 40 minutes after the incident) that revealed that the PA had been called to see the patient after a choking incident. The review revealed an assessment and vital signs were documented by the PA. The notes documented a plan of	A 145		

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A 145	Continued From page 16 observation with vital signs and pulse oximetry every 6 hours times 24 hours. Nursing and HCT notes documented on 04/28/2008 at 2220 and 04/29/2008 at 0355, 0444 and 1800 revealed the patient was resting quietly without complaints and remained on every 15 minute checks. Review of Precaution Flowsheets dated 04/28/2008 through 04/29/2008 revealed every 15 minute documentation of the patient's location and behavior. Review of the flowsheets revealed the patient was located in the dayroom or bedroom and calm or sleeping from 04/28/2008 at 1800 through 04/29/2008 at 2045 (26 hours and 45 minutes); and documentation at 2100 revealed "Code Blue." Review of a late entry nursing note dated 04/28/2008 at 2255 revealed the patient had been placed in the bed around 2045 and was found unresponsive and without a pulse and respirations at 2100. Resuscitative efforts were initiated and the patient was transferred to another hospital where he was pronounced dead at 2201. Further review of the record revealed physician's admission orders dated 04/26/2008 at 0235 for a 2200 calorie 3-4 gram sodium diet (regular diet). Review of the meal consumption record revealed on 04/26/2008, the patient ate no breakfast, ½ lunch and 1/3 dinner; 04/27/2008 refused breakfast, refused lunch and ate 1/3 dinner; 4/28/2008 ate no breakfast, ¼ lunch and refused dinner; and 04/29/2008 ate no breakfast, no lunch and refused dinner. Review of the record revealed no evidence the patient's failure to consume adequate nutritional intake was reported or evaluated. The review revealed no nutritional consult was requested and revealed no evidence the physician was notified about the inadequate nutritional intake.	A 145		

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A 145	Continued From page 17 Further review of the physician's orders revealed an order dated 04/28/2008 at 1522 for "increase fluids 8 oz (ounces) q 2 hr x 3 days (every 2 hours times three days)." Review of an Intake and Output Record revealed a statement handwritten on the top of the sheet that stated increase fluids 8 oz every 2 hours times 3 days, started 04/28/2008 at 1522, ending 05/01/2008 at 1522. Further review of the sheet revealed it was blank on 04/28/2008 with no documentation of intake or output. The review revealed 900 cc (cubic centimeters) oral intake was consumed by the patient during the 1500 through 2300 shift on 04/29/2008. The review revealed the intake and output was not documented for three shifts. Further review of the record revealed no evidence the patient received the 8 oz of fluid every two hours as ordered. Record review revealed no evidence the physician was notified that the orders were not completed. Review of physician's order revealed an order written on 04/28/2008 at 2220 for vital signs with pulse oximetry every 6 hours times 24 hours. Review of the Vital Signs/Weight/Glucose Flow Sheet revealed a notation at the top of the flow sheet that stated vital signs every 6 hours times 24 hours and pulse ox (oximetry) started 04/28/2008 at 2224, ends 04/29/2008 at 2224. Review of the flow sheet revealed after the new order was received at 2220 on 04/28/2008, vital signs were documented as completed on 04/29/2008 at 0845 (8 hours and 45 minutes after last vital signs completed), documented as patient refused on 04/29/2008 at 1545 (7 hours after prior vital signs completed) and documented as completed on 04/29/2008 at 1630. The review revealed the vital signs were not assessed and	A 145		

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A 145	Continued From page 18 documented every six hours as ordered. The record review revealed no evidence the physician was notified that vital signs were not monitored as ordered. Review of the Medication Administration Record (MAR) revealed pulse oximetry (ox) every 6 hours times 24 hours from 04/28/2008 through 04/29/2008. The review revealed the pulse ox was scheduled at 0000, 0600, 1200 and 1800. The review revealed the pulse ox was not completed on 04/29/2008 at 1200. Review of the record revealed no documentation why the pulse ox was not completed as ordered and no evidence the physician was notified. A digital video recording from the hospital's security cameras dated 04/28/2008 through 04/29/2008 was reviewed. The video was recorded from Ward 3 west on the U2 unit and reviewed as recorded time on 04/28/2008 at 2016 through 04/29/2008 at 2127. Review of the video on 04/28/2008 at 2016 revealed HCT #2 administering the medication to Patient #1. The video revealed the patient choked after receiving the medication and fell backward hitting his head on the floor. The video revealed HCT #2 was performing abdominal thrusts on the patient while the patient was on the floor. The video revealed LPN #1 failed to assist the HCT during the emergency situation. The video revealed no assessment of the patient after the choking episode and fall. Further review of the video revealed Patient #1 was assisted by two HCTs from the medication room at 2019. The video revealed the patient was standing in the dayroom at 2222 when HCT #2 took the patient's vital signs. The HCT stretched the cord from the vital sign machine across the room while she appeared to be dancing. The HCT hugged or kissed another HCT who was sitting at a table in	A 145		

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the dayroom playing cards. The video revealed Patient #1 sat in a chair in the dayroom at 2225. The review revealed HCT #1 provided the patient with a cup of liquid at 2238 and the patient was observed to drink the liquid through a straw. Further review of the video revealed the patient remained in the same chair in the day room until 04/29/2008 at 2059 (22 hours and 34 minutes). Review of the video revealed no fluids were offered to the patient after 2238 on 04/28/2008 while the patient remained sitting in the chair in the dayroom (21 hours and 22 minutes without fluids). Review of the patient's intake and output record failed to reveal documentation of this intake on the intake and output flow sheet. There is documentation on 04/29/2008 that the patient received 900 cc of fluid on the 1500 through 2300 shift. Video surveillance revealed that Patient #1 did not receive any fluids during this shift. The video revealed that the patient did not receive any fluids on the night shift on 04/28/2008, day shift on 04/29/2008 or evening shift on 04/29/2008. Further review of the video revealed vital signs were taken on 04/28/2008 at 2222 by HCT #2. Review of the record revealed the vital signs taken at this time were not documented in the record. The video review revealed vital signs were taken on 04/29/2008 at 0847. Review of the video revealed no further vital signs were taken while the patient remained in the chair in the dayroom. Review of the record revealed the patient refused vital signs on 04/29/2008 at 1543. Review of the video revealed no effort was made to take the patients vital signs at 1543. Review of the record revealed the patient's vital signs were documented as taken on 04/29/2008 at 1630. Review of the video confirmed that the vital signs were not taken on 04/29/2008 at 1630. Review of the video revealed that the patient's vital signs

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A 145	Continued From page 20	A 145		

were taken two times during the 22 hours and 34 minutes that the patient remained sitting in a chair in the dayroom. Further review of the video revealed the pulse oximetry was not checked on 04/29/2008 at 1200 which is consistent with the record review. Review of the video revealed that a HCT attempted to offer and encourage the patient to eat breakfast on 04/29/2008 and the patient appeared to refuse. The video revealed that HCTs bring food trays to the ward and allow the trays to sit on a cart unsupervised and allow patients to get their own trays. Further review of the video revealed no staff member offered or encouraged the patient to eat lunch or dinner on 04/29/2008. Review of the video revealed the patient did not receive food during the 22 hours and 34 minutes that he remained in the chair in the dayroom. The review revealed on 04/29/2008 at 2059 two HCTs approached the patient and tried to pull the patient up from the front by holding his hands. The HCTs were unsuccessful after two attempts. After further attempts, the patient was lifted to a standing position. The patient appeared unstable and one of the HCTs pulled a chair over and lowered the patient into the chair. The video shows two HCTs sliding the patient in the chair down the hall toward his bedroom. The video revealed the crash cart being taken down the hallway at 2105. Further review of the video revealed varying levels of staff entering and exiting the dayroom during the 22 hours and 34 minutes the patient remained in the chair in the dayroom. The review revealed HCT staff remained in the dayroom for varying periods of time, watching television throughout the night, playing cards and talking on a cell phone, sometimes in the presence of the RN. Observation on the video revealed a HCT did not enter the dayroom area to check patients until

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A 146	Continued From page 21 04/28/2008 at 0040 (1 hour and 40 minutes after shift started) and the lead tech did not enter the dayroom area until 0113 (2 hours and 13 minutes after the shift started). Interview on 08/08/2008 at 0930 with LPN #1 revealed she was the medication nurse on duty on 04/28/2008 when the patient choked. The nurse stated she was standing behind the medication cart when the patient fell and HCT #2 was performing the Heimlich maneuver. The nurse stated "I watched her do it. I did not request help. I got gloves. See I freaked out. I stood there and freaked out. I have not seen the Heimlich maneuver now in over twenty years. I couldn't see well or tell if he was injured from the fall. He got better. He walked off with assistance. I didn't assess him after the fall. I don't know how (RN #2, the charge nurse) found out. I didn't report it to her. I waited until I went downstairs later and reported it to (the house supervisor). She told me to do an incident report. (PA #8) came up later. I didn't talk with him." Further interview with the nurse revealed she had transcribed the orders for vital signs and pulse ox after the PA saw the patient on 04/28/2008. The nurse stated it is the RN's responsibility to see that the orders are carried out. She stated "I was not aware if the orders were carried out. I'm in the med room." The interview further revealed that LPN #1 did not attend shift report and received a report on medication administration about the patients from the off going nurse. The nurse further stated that the lead HCT oversees the distribution of meal trays and she had no knowledge if patients were eating and that those issues would be reported to the RN. The interview revealed LPN #1 also worked the evening shift on 04/29/2008. The nurse stated	A 145		

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A 145	Continued From page 22 she had seen Patient #1 sleeping in the chair in the dayroom upon her arrival to the ward. The interview revealed the day shift medication nurse had reported that the patient was sedated and medications were being held. The nurse stated "I assumed the RN knew about his status. I read his TB skin test at 1800. He didn't talk to me. He was sleeping." Interview with HCT #2 was attempted. The staff member was not available for interview. Interview on 08/08/2008 at 1020 with RN #2 revealed she was the charge nurse on duty during the 1500 - 2300 shift on 04/28/2008. The nurse stated that she had not been made aware that HCT #1 administered the medication to Patient #1 on 04/28/2008. The interview revealed that the HCT should not have administered the medication. The interview revealed that HCT #1 had reported the choking to the charge nurse. The nurse stated "She told me that she had gotten him back to his room. I didn't go check on him. I didn't know I needed to do an incident report. (The house supervisor) called me and told me to do an incident report and notify (PA #8). There was a delay in notifying the PA because I didn't know I was supposed to call him. I don't remember if I talked with (the PA) about the incident. I was not aware the patient fell. I don't know if he was aware of the fall. I didn't talk with (LPN #1) about what happened." Further interview revealed the nurse did not notify the house supervisor of the choking incident or the fall. The interview revealed that the charge nurse was not aware of the new orders written by the PA and that the LPN would have transcribed the orders. The nurse stated "I didn't do observations that day. I was aware that he	A 145		

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A 145	Continued From page 23 (Patient #1) was sitting in the chair. I did not talk with him the entire shift." The nurse stated that she relied on staff to report if patients are not eating. PA #B was not available for interview during the survey. Interview on 08/09/2008 at 1350 with an administrative staff member revealed that the staff member had reviewed the video recording as part of an investigation of abuse/neglect after the patient had died. The staff member revealed that the neglect was substantiated. The staff member revealed that the patient's basic needs were not met and that he was not provided toileting, nutrition or hydration during the 22 hours and 34 minutes he was sitting in the chair in the dayroom. The staff member revealed that review of the video recording revealed that staff documentation in the record was not consistent with the video and that the investigation revealed that some of the documentation was falsified. The staff member revealed that the investigation and video review revealed that staff were not following hospital policies and procedures. The interview confirmed that the nursing staff failed to provide ongoing evaluation, monitoring and delivery of care to meet the patient's basic care needs. Consequently, Patient #1 became choked after receiving medication from an unlicensed personnel on 04/28/2008 at 2020 and subsequently fell. The medication nurse (LPN) staff failed to respond to the emergency, failed to assess the patient after the incident and failed to report the incident to the charge registered nurse. The charge nurse (RN) failed to assess the	A 145		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 145	Continued From page 24 patient, failed to report the incident to the supervisor, delayed reporting the choking incident to the PA and failed to report the fall to the PA. Patient #1 sat down in a chair in the dayroom (high traffic area) on 04/28/2008 at 2225 after the fall and choking incident at 2020. The patient remained in the same chair for 22 hours and 34 minutes. The patient was seated in the chair over a duration of four different shifts of care providers: evening shift on 04/28/2008, night shift on 04/28/2008, day shift on 04/29/2008 and evening shift on 04/29/2008. Staff members failed to follow physician's orders for fluids and vital signs and failed to offer toileting, fluids and nutrition during the 22 hours and 34 minutes that the patient remained in the chair in the dayroom. Nursing staff failed to assess, supervise and monitor the patient to prevent neglect.	A 145		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on closed record review, digital video recording review, policy review, observation and staff interview, the hospital failed to have an organized nursing service as evidenced by failing to prevent neglect. The facility nursing staff failed to assess, supervise and monitor the delivery of care to assure basic needs (toileting, nutrition and	A 385		

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	344003	A. BUILDING _____ B. WING _____	C 08/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 385	Continued From page 25 hydration) were provided and failed to ensure medication was administered by licensed, trained staff for 1 of 3 sampled records (#1). The hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. The finding include: A) The hospital's nursing staff failed to assess, supervise and monitor the delivery of care to assure basic needs (toileting, nutrition and hydration) were provided for 1 of 3 sampled records (#1). ~cross refer to 482.23(b)(3) Nursing Services Tag A0385 B) The hospital's staff failed to ensure the delivery of care was provided to prevent neglect as evidenced by failing to provide supervision, toileting needs, nutritional needs and hydration for 1 of 3 sampled records (#1). ~cross refer to 482.23(b) Nursing Services Tag A0392 C) The hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. ~cross refer to 482.23(b)(5) Nursing Services Tag A0397 D) The hospital failed to ensure medication was administered by licensed, trained staff for 1 of 3 sampled records (#1). ~cross refer to 482.23(c)(1) Nursing Services Tag	A 385		

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	344003	A. BUILDING _____ B. WING _____	C 08/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 385	Continued From page 26 A0404	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on closed record review, digital video recording review and staff interview, the hospital's staff failed to ensure the delivery of care was provided to prevent neglect as evidenced by failing to provide supervision, toileting needs, nutritional needs and hydration for 1 of 3 sampled records (#1). The findings include: Closed record review of Patient #1 revealed [redacted] admitted [redacted] with [redacted] Review of the record revealed the patient choked after taking medication from unlicensed personnel (HCT) on 04/28/2008 at 2020. Review of the record revealed a note by PA #8 (Physician Assistant) dated 04/28/2008 at	A 392		

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	344003	A. BUILDING _____ B. WING _____	C 08/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 392	Continued From page 27 2200 (1 hour and 40 minutes after the incident) that revealed that the PA had been called to see the patient after a choking incident. The review revealed an assessment was documented by the PA. The notes documented a plan of observation with vital signs and pulse oximetry every 6 hours times 24 hours. Nursing and HCT notes documented on 04/28/2008 at 2220 and 04/29/2008 at 0355, 0444 and 1800 revealed the patient was resting quietly without complaints and remained on every 15 minute checks. Review of Precaution Flowsheets dated 04/28/2008 through 04/29/2008 revealed every 15 minute documentation of the patient's location and behavior. Review of the flowsheets revealed the patient was located in the dayroom or bedroom and calm or sleeping from 04/28/2008 at 1800 through 04/29/2008 at 2045 (26 hours and 45 minutes); and documentation at 2100 revealed "Code Blue." Review of a late entry nursing note dated 04/28/2008 at 2255 revealed the patient had been placed in the bed around 2045 and was found unresponsive and without a pulse and respirations at 2100. Resuscitative efforts were initiated and the patient was transferred to another hospital where he was pronounced dead at 2201. Further review of the record revealed physician's admission orders dated 04/26/2008 at 0235 for a 2200 calorie 3-4 gram sodium diet (regular diet). Review of the meal consumption record revealed on 04/26/2008, the patient ate no breakfast, ½ lunch and 1/3 dinner; 04/27/2008 refused breakfast, refused lunch and ate 1/3 dinner; 4/28/2008 ate no breakfast, ¾ lunch and refused dinner; and 04/29/2008 ate no breakfast, no lunch and refused dinner. Review of the record revealed no evidence the patient's failure to	A 392		

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A 392	Continued From page 28 consume adequate nutritional intake was reported or evaluated. The review revealed no nutritional consult was requested and revealed no evidence the physician was notified about the inadequate nutritional intake. Further review of the physician's orders revealed an order dated 04/28/2008 at 1522 for "increase fluids 8 oz (ounces) q 2 hr x 3 days (every 2 hours times three days)." Review of an Intake and Output Record revealed a statement handwritten on the top of the sheet that stated increase fluids 8 oz every 2 hours times 3 days, started 04/28/2008 at 1522, ending 05/01/2008 at 1522. Further review of the sheet revealed it was blank on 04/28/2008 with no documentation of intake or output. The review revealed 900 cc (cubic centimeters) oral intake was consumed by the patient during the 1500 through 2300 shift on 04/29/2008. The review revealed the intake and output was not documented for three shifts. Further review of the record revealed no evidence the patient received the 8 oz of fluid every two hours as ordered. Record review revealed no evidence the physician was notified that the orders were not completed. Review of physician's order revealed an order written on 04/28/2008 at 2220 for vital signs with pulse oximetry every 6 hours times 24 hours. Review of the Vital Signs/Weight/Glucose Flow Sheet revealed a notation at the top of the flow sheet that stated vital signs every 6 hours times 24 hours and pulse ox (oximetry) started 04/28/2008 at 2224, ends 04/29/2008 at 2224. Review of the flow sheet revealed after the new order was received at 2220 on 04/28/2008, vital signs were documented as completed on 04/29/2008 at 0845 (8 hours and 45 minutes after	A 392		

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A 392	Continued From page 29 last vital signs completed), documented as patient refused on 04/29/2008 at 1545 (7 hours after prior vital signs completed) and documented as completed on 04/29/2008 at 1630. The review revealed the vital signs were not assessed and documented every six hours as ordered. The record review revealed no evidence the physician was notified that vital signs were not monitored as ordered. Review of the Medication Administration Record (MAR) revealed pulse oximetry (ox) every 6 hours times 24 hours from 04/28/2008 through 04/29/2008. The review revealed the pulse ox was scheduled at 0000, 0600, 1200 and 1800. The review revealed the pulse ox was not completed on 04/29/2008 at 1200. Review of the record revealed no documentation why the pulse ox was not completed as ordered and no evidence the physician was notified. A digital video recording from the hospital's security cameras dated 04/28/2008 through 04/29/2008 was reviewed. The video was recorded from Ward 3 west on the U2 unit and reviewed as recorded time on 04/28/2008 at 2016 through 04/29/2008 at 2127. Review of the video revealed the patient fell backward hitting his head on the floor after choking on medication on 04/28/2008 at 2016. Review of the video revealed HCT #2 was performing abdominal thrusts on the patient while the patient was on the floor. Further review of the video revealed the patient was standing in the dayroom at 2222 when HCT #2 took the patient's vital signs. Review revealed the HCT stretched the cord from the vital sign machine across the room while she appeared to be dancing. Further review revealed the HCT hugged or kissed another HCT who was sitting at a table in the dayroom playing cards. Review of the video revealed Patient #1 sat in a	A 392		

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A 392	Continued From page 30	A 392		

chair in the dayroom at 2225. The review revealed HCT #1 provided the patient with a cup of liquid at 2238 and the patient was observed to drink the liquid through a straw. Further review of the video revealed the patient remained in the same chair in the day room until 04/29/2008 at 2059 (22 hours and 34 minutes). Review of the video revealed no fluids were offered to the patient after 2238 on 04/28/2008 while the patient remained sitting in the chair in the dayroom (21 hours and 22 minutes without fluids). Review of the patient's intake and output record failed to reveal documentation of this intake on the intake and output flow sheet. There is documentation on 04/29/2008 that the patient received 900 cc of fluid on the 1500 through 2300 shift. Video surveillance revealed that Patient #1 did not receive any fluids during this shift. The video revealed that the patient did not receive any fluids on the night shift on 04/28/2008, day shift on 04/29/2008 or evening shift on 04/29/2008. Further review of the video revealed vital signs were taken on 04/28/2008 at 2222 by HCT #2. Review of the record revealed the vital signs taken at this time were not documented in the record. The video review revealed vital signs were taken on 04/29/2008 at 0847. Review of the video revealed no further vital signs were taken while the patient remained in the chair in the dayroom. Review of the record revealed the patient refused vital signs on 04/29/2008 at 1543. Review of the video revealed no effort was made to take the patients vital signs at 1543. Review of the record revealed the patient's vital signs were documented as taken on 04/29/2008 at 1630. Review of the video confirmed that the vital signs were not taken on 04/29/2008 at 1630. Review of the video revealed that the patient's vital signs were taken two times during the 22 hours and 34

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A 392	Continued From page 31	A 392		

minutes that the patient remained sitting in a chair in the dayroom. Further review of the video revealed the pulse oximetry was not checked on 04/29/2008 at 1200 which is consistent with the record review. Review of the video revealed that a HCT attempted to offer and encourage the patient to eat breakfast on 04/29/2008 and the patient appeared to refuse. The video revealed that HCTs bring food trays to the ward and allow the trays to sit on a cart unsupervised and allow patients to get their own trays. Further review of the video revealed no staff member offered or encouraged the patient to eat lunch or dinner on 04/29/2008. Review of the video revealed the patient did not receive food during the 22 hours and 34 minutes that he remained in the chair in the dayroom. The review revealed on 04/29/2008 at 2059 two HCTs approached the patient and tried to pull the patient up from the front by holding his hands. The HCTs were unsuccessful after two attempts. After further attempts, the patient was lifted to a standing position. The patient appeared unstable and one of the HCTs pulled a chair over and lowered the patient into the chair. The video shows two HCTs sliding the patient in the chair down the hall toward his bedroom. The video revealed the crash cart being taken down the hallway at 2105. Further review of the video revealed varying levels of staff entering and exiting the dayroom during the 22 hours and 34 minutes the patient remained in the chair in the dayroom. The review revealed HCT staff remained in the dayroom for varying periods of time, watching television throughout the night, playing cards and talking on a cell phone, sometimes in the presence of the RN. Observation on the video revealed a HCT did not enter the dayroom area to check patients until 04/28/2008 at 0040 (1 hour and 40 minutes after

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A 392	Continued From page 32 shift started) and the lead tech did not enter the dayroom area until 0113 (2 hours and 13 minutes after the shift started). Interview on 08/09/2008 at 1350 with an administrative staff member revealed that the staff member had reviewed the video recording as part of an investigation of abuse/neglect after the patient had died. The staff member revealed that the neglect was substantiated. The staff member revealed that the patient's basic needs were not met and that he was not provided toileting, nutrition or hydration during the 22 hours and 34 minutes he was sitting in the chair in the dayroom. The staff member revealed that review of the video recording revealed that staff documentation in the record was not consistent with the video and that the investigation revealed that some of the documentation was falsified. The staff member revealed that the investigation and video review revealed that staff were not following hospital policies and procedures. The interview confirmed that the nursing staff failed to provide ongoing evaluation, monitoring and delivery of care to meet the patient's basic care needs.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on policy review, closed record review, digital video recording review and staff interview,	A 395		

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A 395	Continued From page 33 the hospital's nursing staff failed to assess, supervise and monitor the delivery of care to assure basic needs (toileting, nutrition and hydration) were provided for 1 of 3 sampled records (#1). The findings include: Review of the "Meals and Nourishment" policy effective March 2004 revealed "All clients will be provided with adequate meals and nourishments per a regular schedule ...If patient refuses meals, RN (registered nurse) assesses and/or a referral to the dietician is implemented .....Nursing personnel shall monitor patients' nutritional needs, record food intake and report weight loss/gain ....Food and fluid intake shall be observed and documented on the multi-purpose flow sheet by nursing personnel at each meal/nourishment time ....Any meal/nourishment refused by a nursing facility patient shall be reported to the charge nurse." Closed record review of Patient #1 revealed a [redacted] admitted [redacted] with [redacted]. Review of the medication administration record (MAR) revealed four oral medications were administered on 04/28/2008 at 2000 by LPN #1 (licensed practical nurse). Review of a nursing note by LPN #1 dated 04/28/2008 at 2020 documented "Pt. (patient) was taking his po (oral) meds and started choking. Heimlich maneuver was used and patient was assisted out of interview room. Pt. was able to stand up and walk with assistance to bed. Pt. was breathing without difficulty." Review of the record revealed a note by PA #B (Physician Assistant) dated 04/28/2008 at 2200 (1 hour and	A 395		

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A 395	Continued From page 34 40 minutes after the incident) that revealed that the PA had been called to see the patient after a choking incident. The note revealed the patient denied breathing problems, shortness of breath, chest pain or palpitations and was drinking fluids without problems. Vital signs were documented as temperature 96 degrees Fahrenheit, respirations 20, pulse 81, blood pressure 119/80 and pulse oximetry 98%. The notes documented a plan of observation with vital signs and pulse oximetry every 6 hours times 24 hours. Nursing notes on 04/28/2008 at 2220 revealed the patient remained on every 15 minute checks and will continue to monitor. Health care technician (HCT) notes on 04/29/2008 at 0355 documented the patient was resting with his eyes closed in the dayroom chair without complaints. Nursing notes at 0444 documented the patient was resting with eyes closed in the dayroom since the writers arrival without distress. Review of a physician's note at 0920 revealed the patient's lithium (medication) level was high and he had discontinued the medication yesterday. The note also documented that the patient had choked on meds "probably secondary to Depakote, which is a large pill. Will discontinue Depakote for now given he already has sufficient levels of a mood stabilizer in his system." Nursing notes at 1800 documented the patient "has been asleep almost all day. Did answer questions but went right back to sleep. Continues on q (every) 15 min. (minute) checks. VSS (vital signs stable). Will continue to monitor and document. Review of a physician's note on 04/29/2008 at 2134 documented "I received a page of Code Blue over the beeper and responded. Hand off communication given to (physician) at (another hospital emergency department) of patient in cardiopulmonary arrest ....Patient transferred via EMS (ambulance) to	A 395		

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A 395	Continued From page 35 (hospital emergency department)." Review of a PA note at 2135 revealed the PA responded to the Code Blue that was called at 2105. The note documented that staff reported that the patient was assisted to bed around 2045 and when he was checked, the patient was found to have soiled himself and was unresponsive. Review of a physician's note at 2210 documented he had received a call from the hospital emergency department that the patient was pronounced dead at 2201. Review of a late entry nursing note at 2255 documented the patient was assisted to bed at 2045. "Pt sleeping in chair since I arrived at 1900. When pt checked at 2100, patient had urinated on himself and was unresponsive. No breathing or pulse noted. CPR (resuscitative measures) started. Code Blue (emergency response) called and EMS contacted ..." Further review of the record revealed physician's admission orders dated 04/26/2008 at 0235 for a 2200 calorie 3-4 gram sodium diet (regular diet). Review of the meal consumption record revealed on 04/26/2008, the patient ate no breakfast, ⅓ lunch and 1/3 dinner; 04/27/2008 refused breakfast, refused lunch and ate 1/3 dinner; 4/28/2008 ate no breakfast, ¼ lunch and refused dinner; and 04/29/2008 ate no breakfast, no lunch and refused dinner. Review of the record revealed no evidence the nursing staff had evaluated the patient's lack of nutrition. The review revealed no nutritional consult was requested and revealed no evidence the physician was notified about the inadequate nutritional intake. Further review of the physician's orders revealed an order dated 04/28/2008 at 1522 for "increase fluids 8 oz (ounces) q 2 hr x 3 days (every 2 hours	A 395		

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A 395	Continued From page 36 times three days)." Review of an Intake and Output Record revealed a statement handwritten on the top of the sheet that stated increase fluids 8 oz every 2 hours times 3 days, started 04/28/2008 at 1522, ending 05/01/2008 at 1522. Further review of the sheet revealed it was blank on 04/28/2008 with no documentation of intake or output. The review revealed 900 cc (cubic centimeters) oral intake was consumed by the patient during the 1500 through 2300 shift on 04/29/2008. The review revealed the intake and output was not documented for three shifts. Further review of the record revealed no evidence the patient received the 8 oz of fluid every two hours as ordered. Record review revealed no evidence the physician was notified that the orders were not completed. Review of physician's order revealed an order written on 04/28/2008 at 2220 for vital signs with pulse oximetry every 6 hours times 24 hours. Review of the Vital Signs/Weight/Glucose Flow Sheet revealed a notation at the top of the flow sheet that stated vital signs every 6 hours times 24 hours and pulse ox (oximetry) started 04/28/2008 at 2224, ends 04/29/2008 at 2224. Review of the flow sheet revealed after the new order was received at 2220 on 04/28/2008, vital signs were documented as completed on 04/29/2008 at 0845 (8 hours and 45 minutes after last vital signs completed), documented as patient refused on 04/29/2008 at 1545 (7 hours after prior vital signs completed) and documented as completed on 04/29/2008 at 1630. The review revealed the vital signs were not assessed and documented every six hours as ordered. The review revealed no evidence the nursing staff was assessing the patient's vital signs as ordered after the patient's choking episode and fall at 2020 on	A 395		

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A 395	Continued From page 37 04/28/2008. The record review revealed no evidence the physician was notified that vital signs were not monitored as ordered. Review of the Medication Administration Record (MAR) revealed pulse oximetry (ox) every 6 hours times 24 hours from 04/28/2008 through 04/29/2008. The review revealed the pulse ox was scheduled at 0000, 0600, 1200 and 1800. The review revealed the pulse ox was not completed on 04/29/2008 at 1200. Review of the record revealed no documentation why the pulse ox was not completed as ordered and no evidence the physician was notified. A digital video recording from the hospital's security cameras dated 04/28/2008 through 04/29/2008 was reviewed. The video was recorded from Ward 3 West on the U2 unit and reviewed as recorded time on 04/28/2008 at 2016 through 04/29/2008 at 2127. Review of the video revealed on 04/28/2008 at 2016 HCT #2 administered medication to Patient #1. The video revealed the patient choked after receiving the medication and fell backward hitting his head on the floor. The video revealed HCT #2 was performing abdominal thrusts on the patient while the patient was on the floor. The video revealed LPN #1 failed to assist the HCT during the emergency situation. The video revealed no assessment of the patient after the choking episode and fall. Further review of the video revealed Patient #1 was assisted by two HCTs from the medication room at 2019. The video revealed the patient was standing in the dayroom at 2222 when HCT #2 took the patient's vital signs. The video revealed Patient #1 sat in a chair in the dayroom at 2225. The review revealed HCT #1 provided the patient with a cup of liquid at 2238 and the patient was observed to	A 395		

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drink the liquid through a straw. Further review of the video revealed the patient remained in the same chair in the day room until 04/29/2008 at 2059 (22 hours and 34 minutes). Review of the video revealed no fluids were offered to the patient after 2238 on 04/28/2008 while the patient remained sitting in the chair in the dayroom (21 hours and 22 minutes without fluids). Review of the patient's intake and output record failed to reveal documentation of this intake on the intake and output flow sheet. There is documentation on 04/29/2008 that the patient received 900 cc of fluid on the 1500 through 2300 shift. Video surveillance revealed that Patient #1 did not receive any fluids during this shift. The video revealed that the patient did not receive any fluids on the night shift on 04/28/2008, day shift on 04/29/2008 or evening shift on 04/29/2008. Further review of the video revealed vital signs were taken on 04/28/2008 at 2222 by HCT #2. Review of the record revealed the vital signs taken at this time were not documented in the record. The video review revealed vital signs were taken on 04/29/2008 at 0847. Review of the video revealed no further vital signs were taken while the patient remained in the chair in the dayroom. Review of the record revealed the patient refused vital signs on 04/29/2008 at 1543. Review of the video revealed no effort was made to take the patients vital signs at 1543. Review of the record revealed the patient's vital signs were documented as taken on 04/29/2008 at 1630. Review of the video confirmed that the vital signs were not taken on 04/29/2008 at 1630. Review of the video revealed that the patient's vital signs were taken two times during the 22 hours and 34 minutes that the patient remained sitting in a chair in the dayroom. Further review of the video revealed the pulse oximetry was not checked on

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A 395	Continued From page 39 04/29/2008 at 1200 which is consistent with the record review. Review of the video revealed that a HCT attempted to offer and encourage the patient to eat breakfast on 04/29/2008 and the patient appeared to refuse. The video revealed that HCTs bring food trays to the ward and allow the trays to sit on a cart unsupervised and allow patients to get their own trays. Further review of the video revealed no staff member offered or encouraged the patient to eat lunch or dinner on 04/29/2008. Review of the video revealed the patient did not receive food during the 22 hours and 34 minutes that he remained in the chair in the dayroom. The review revealed on 04/29/2008 at 2059 two HCTs approached the patient and tried to pull the patient up from the front by holding his hands. The HCTs were unsuccessful after two attempts. After further attempts, the patient was lifted to a standing position. The patient appeared unstable and one of the HCTs pulled a chair over and lowered the patient into the chair. The video shows two HCTs sliding the patient in the chair down the hall toward his bedroom. The video revealed the crash cart being taken down the hallway at 2105. Interview on 08/08/2008 at 0930 with LPN #1 revealed she was the medication nurse on duty on 04/28/2008 when the patient choked. The nurse stated she was standing behind the medication cart when the patient fell and HCT #2 was performing the Heimlich maneuver. The nurse stated "I watched her do it. I did not request help. I got gloves. See I freaked out. I stood there and freaked out. I have not seen the Heimlich maneuver now in over twenty years. I couldn't see well or tell if he was injured from the fall. He got better. He walked off with assistance. I didn't assess him after the fall. I don't know how	A 395		

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A 395	Continued From page 40 (RN #2, the charge nurse) found out. I didn't report it to her. I waited until I went downstairs later and reported it to (the house supervisor). She told me to do an incident report. (PA #8) came up later. I didn't talk with him." Further interview with the nurse revealed she had transcribed the orders for vital signs and pulse ox after the PA saw the patient on 04/28/2008. The nurse stated it is the RN's responsibility to see that the orders are carried out. She stated "I was not aware if the orders were carried out. I'm in the med room." The interview further revealed that LPN #1 did not attend shift report and received a report on medication administration about the patients from the off going nurse. The nurse further stated that the lead HCT oversees the distribution of meal trays and she had no knowledge if patients were eating and that those issues would be reported to the RN. The interview revealed LPN #1 also worked the evening shift on 04/29/2008. The nurse stated she had seen Patient #1 sleeping in the chair in the dayroom upon her arrival to the ward. The interview revealed the day shift medication nurse had reported that the patient was sedated and medications were being held. The nurse stated "I assumed the RN knew about his status. I read his TB skin test at 1800. He didn't talk to me. He was sleeping." Interview on 08/08/2008 at 1020 with RN #2 revealed she was the charge nurse working on 04/28/2008 when Patient #1 choked and fell. The interview revealed that HCT #1 had reported the incident to the charge nurse. The nurse stated "She told me that she had gotten him back to his room. I didn't go check on him. I didn't know I needed to do an incident report. (The house supervisor) called me and told me to do an	A 395		

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incident report and notify (PA #B). There was a delay in notifying the PA because I didn't know I was supposed to call him. I don't remember if I talked with (the PA) about the incident. I was not aware the patient fell. I don't know if he was aware of the fall. I didn't talk with (LPN #1) about what happened." Further interview revealed the nurse did not notify the house supervisor of the choking incident or the fall. The interview revealed that the charge nurse was not aware of the new orders written by the PA and that the LPN would have transcribed the orders. The nurse stated "I didn't do observations that day. I was aware that he (Patient #1) was sitting in the chair. I did not talk with him the entire shift." The nurse stated that she relied on staff to report if patients are not eating. The staff member further stated that she was not told that HCT #2 had administered the patient's medication prior to the choking episode on 04/28/2008.

PA #B was not available for interview during the survey.

Consequently, Patient #1 became choked after receiving medication on 04/28/2008 at 2020 and subsequently fell. The medication nurse (LPN) failed to respond to the emergency, failed to assess the patient after the incident and failed to report the incident to the charge nurse (RN). The charge nurse (RN) failed to assess the patient, failed to report the incident to the supervisor, delayed reporting the choking incident to the PA and failed to report the fall to the PA. Patient #1 sat down in a chair in the dayroom (high traffic area) on 04/28/2008 at 2225 after the fall and choking incident at 2020. The patient remained in the same chair for 22 hours and 34 minutes. The patient was seated in the chair over a duration of

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A 395	Continued From page 42 four different shifts of care providers: evening shift on 04/28/2008, night shift on 04/28/2008, day shift on 04/29/2008 and evening shift on 04/29/2008. Staff members failed to follow physician's orders for fluids and vital signs and failed to offer toileting, fluids and nutrition during the 22 hours and 34 minutes that the patient remained in the chair in the dayroom. Nursing staff failed to assess, supervise and monitor the patient to prevent neglect.	A 395		
A 397	482.23(b)(5) PATIENT CARE ASSIGMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on policy review, observation and staff interviews, the hospital's nursing staff failed to delegate and monitor patient care assignments to assure nutritional needs were met. The findings include: Review of the "Meals and Nourishment" policy effective March 2004 revealed "All clients will be provided with adequate meals and nourishments per a regular schedule ...If patient refuses meals, RN (registered nurse) assesses and/or a referral to the dietician is implemented .....Nursing personnel shall monitor patients' nutritional needs, record food intake and report weight loss/gain ....Food and fluid intake shall be	A 397		

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A 397	Continued From page 43 observed and documented on the multi-purpose flow sheet by nursing personnel at each meal/nourishment time ....Any meal/nourishment refused by a nursing facility patient shall be reported to the charge nurse." Observation on 08/09/2008 at 1210 of the U2 cafeteria revealed patients eating in the dining area with three staff members present. Observation revealed patients covered their trays after eating and returned the trays to a cart. Interview on 08/09/2008 at 1215 with HCT #3 (a staff member that was present in the dining room during the observation) revealed she had documented the meal consumption for three of the patients in the dining room. Interview on 08/09/2008 at 1217 with HCT #4 (a staff member that was present in the dining room during the observation) revealed she had documented the meal consumption for four of the patients in the dining room. Interview on 08/09/2008 at 1219 with HCT #5 (a staff member that was present in the dining room during the observation) revealed there were 14 total patients eating in the dining room. The staff member was asked about monitoring of meal consumption for the patients in the dining room. The staff member stated "I am doing accountability today. I do not document meal consumption when I am doing accountability." Interview on 08/09/2008 at 1220 with an administrative staff member revealed the staff are supposed to look at the trays and document what the patients eat. The staff member confirmed there were a total of 14 patients in the dining	A 397		

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A 397	Continued From page 44 room area with three staff. The staff member confirmed that 7 of the 14 patients (50%) did not have documentation of meal consumption.	A 397		
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on policy review, closed record review, digital video recording review and staff interview, the hospital failed to ensure medication was administered by licensed, trained staff for 1 of 3 sampled records (#1). The findings include: Review of the hospital's "Medication Administration" policy revealed medications are administered by registered nurses (RNs) or licensed practical nurses (LPNs) in the Nursing Services Department. The policy stated that a health care technician (HCT) was assigned to stand at the cart with the nurse at medication time for the purpose of preventing patients from crowding around the cart, to assist with patients who may be hostile and grabbing and reaching for items on the cart, to assist in pouring juice	A 405		

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A 405	Continued From page 45 and/or obtaining vital signs. Further review of the policy revealed that the RNs and LPNs must be certified in medication administration prior to administering medications. Closed record review of Patient #1 revealed [redacted] admitted [redacted] Review of the medication administration record (MAR) revealed four oral medications were administered on 04/28/2008 at 2000 by LPN #1. Review of a nursing note by LPN #1 dated 04/28/2008 at 2020 documented "PL (patient) was taking his po (oral) meds and started choking. Heimlich maneuver was used and patient was assisted out of interview room. Pt. was able to stand up and walk with assistance to bed. Pt. was breathing without difficulty." Review of a digital video recording revealed the patient entered the interview room on 04/28/2008 at 2016 to get his medication. The video revealed that HCT #2 administered the medication. The video revealed that the patient began to cough, and then fell backward hitting his head on the floor after he began choking. The video review revealed HCT began abdominal thrusts on the patient after he fell to the floor. Interview on 08/08/2008 at 0930 with LPN #1 revealed HCT #2 administered the medication to Patient #1 on 04/28/2008. The staff member stated the HCT should be pouring juice, keeping the patients away from the cart and calling the patients. The staff member stated "She tells me I am slow. She's at me if I double check medicine. I had put the medication on top of the cart in a cup. I had called him. He came. She picked up the medicine and gave it because I'm slow. She had done that before. I have told the RNs in the	A 405		

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A 405	Continued From page 46 past that she had done that and they just laughed at me.' No, I didn't tell the nurse about her giving the medication. I don't know if the charge nurse (RN) was aware of her giving meds." Interview with HCT #2 was attempted. The staff member was not available for interview. Interview on 08/08/2008 at 1020 with RN #2 revealed she was the charge nurse on duty during the 1500 - 2300 shift on 04/28/2008. The nurse stated that she had not been made aware that HCT #1 administered the medication to Patient #1 on 04/28/2008. The interview revealed that the HCT should not have administered the medication.	A 405		